

Client No. <b>2036</b>		Client Name <b>O.H. materials</b>				Location <b>1802 osage st. utca</b>		Date <b>5/19/87</b>																
Facility Equipment	Detect Clock <b>1</b>	Weapon No. <b>1</b>	Holster <b>1</b>	Nightstick <b>1</b>	Raincoat <b>1</b>	Flashlight <b>1</b>	Other <b>gate ; Trailer keys</b>																	
Officers: Fully explain all items marked "Yes" with time and all detail. For additional space use reverse side and attach incident reports.			Officer - Day Shift (Name) <b>Off: K. Felix</b>			Officer - Swing Shift (Name) <b>Off: Del Vecchio</b>			Officer - Grave Shift (Name) <b>Dick Kokoszki</b>															
			Shift Began <b>8 AM</b> Ended <b>4 PM</b>			Shift Began <b>4 AM</b> Ended <b>12 PM</b>			Shift Began <b>12 AM</b> Ended <b>8 PM</b>															
Observations or actions taken	Yes	No	Explanation			Yes	No	Explanation			Yes	No	Explanation											
Rounds or stations missed		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
Unlocked doors, gates or windows		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
Unlocked vaults or safes		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
Fire-smoke-or hazards		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
1. Extinguishers missing or defective		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
2. Sprinkler system defective		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
3. Fire doors or exits blocked		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
4. Rubbish accumulation		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
5. Motors running		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
6. Lights left burning		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>	<b>As required</b>				<input checked="" type="checkbox"/>	<b>LIGHTS OUT.</b>												
Injury hazards		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>	<b>0600</b>											
Visitors <b>EPAD OHM People on site</b>		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>	<b>OHM EPAD MEN ON</b>												
Trespassing		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>	<b>SITE</b>											
Violation of company rules		<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>												
Remarks																								
<b>IMPORTANT: If you were ill or injured please explain on the reverse side of this form and call your supervisor before leaving this post.</b>																								
1. Were you injured during this tour?	Day Shift	1.	Yes	No	2.	Yes	No	3.	Swing Shift	1.	Yes	No	2.	Yes	No	3.	Grave Shift	1.	Yes	No	2.	Yes	No	3.
			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>						<input checked="" type="checkbox"/>				
2. Did you suffer any illness?			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>						<input checked="" type="checkbox"/>				
3. Have you reported all accidents coming to your attention?			<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>					<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>						<input checked="" type="checkbox"/>				
Signatures	Day Shift	1.	<b>Kenneth Felix</b>						Swing Shift	1.	<b>Del Vecchio</b>						Grave Shift	1.	<b>Dick Kokoszki</b>					
Signatures		2.								2.								2.						
Signatures		3.								3.								3.						

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